

metronidazole, with initial cure rates often >90%,¹⁵ the limited worldwide availability of these therapies, added expense, lessened patient acceptability, and uncertainty of patient compliance with these therapies and regimens mitigate against their widespread use. In addition, a programme introducing widespread therapy for BV in populations with high BV prevalence, as found in Africa, would need to monitor antimicrobial resistance not only of the organisms characteristic of BV (to ensure continuing efficacy) but ideally also of other micro-organisms.

The one study which evaluated an intervention for BV (a single 2 g dose of metronidazole at two 10 month intervals) did not show a significant decline in BV prevalence in the intervention compared with the control group at either the first or second post-treatment measurements, compared with one another or with pretherapy prevalences.¹⁶ Although a modest decline occurred in the intervention group at the second post-treatment visit (46.6% *v* 53.8% in the control group), these prevalences were not statistically different and quite close to the pretreatment values of 50.4% and 51.2%, respectively. There was no difference in HIV acquisition between the treatment and control groups. A substudy of pregnant women did show a difference in BV prevalence post partum (39.1% *v* 52.8%), and it may be because these women were studied an average of only 4 months following therapy. Again, no difference in HIV acquisition between the two groups was demonstrated.

Given the therapeutic inadequacies for BV, and that the single study which evaluated a therapeutic intervention for BV to prevent HIV infection showed no significant effect, approaches to prevention of BV would be attractive; however, prevention options are also limited. Why women acquire or reacquire BV is not well known and the recognised risk factors for BV—for example, multiple or new sex partners, are generally not easy to modify. Replacement of the altered flora of BV with hydrogen peroxide producing lactobacilli appears promising but requires further investigation. Intravaginal microbicides containing nonoxynol-9, which might be prophylactically used against STIs and HIV, are also active against some of the organisms that characterise BV, although data on the clinical use of nonoxynol-9 for prevention of BV are conflicting. Importantly, lactobacilli concentrations may decrease transiently after use of nonoxynol-9 and the effects of chronic use of such agents need to be further evaluated.¹⁷

Data on the association between BV and HIV have shed light on an important risk factor for HIV infection. The

challenge now is to determine how to reduce BV related HIV transmission. More research is needed on BV, its aetiology, and how to better treat and prevent it.

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The British Co-operative Clinical Group (BCCG)

Tempus fugit. The British Co-operative Clinical Group (BCCG) was established in 1951 for the immediate purpose of collecting information concerning the venereal diseases from case records available in the United Kingdom. It was due to the perspicacity of one distinguished consultant venereologist (for that is what he called himself), the late Dr R R (Dick) Willcox, who died in 1985, that this group, still flourishing, exists, is independent, finds information on behalf of the specialty of genitourinary medicine in the United Kingdom, and is producing more publications from its numerous projects than ever before. I chaired the BCCG for some years between 1990 and 1995, before handing on to my successor, Dr George Kinghorn ably assisted by Dr Chris Carne, who have kept me informed about recent developments. I

suppose I am seen as a link between the events of over 25 years ago and the present. Hence tempus fugit. Among other achievements, Dr Willcox travelled and wrote more than any other British contemporary venereologist of his time, and was on the council (and was president 1965–7) of the Medical Society for the Study of Venereal Diseases (MSSVD) for 31 years from 1953 to 1984, reporting about the BCCG annually to council and the society. He was an advocate of cross fertilisation from other disciplines, especially epidemiology. At the present time, epidemiologists from the Public Health Laboratory Service (PHLS) Communicable Disease Surveillance Centre (CDSC) belong to the BCCG and bring their expertise to the design and analysis of various studies.

The great pioneering work of the BCCG was initiated and coordinated by Dick Willcox. Two reports were published in this journal in 1973¹ and 1980,² the latter just before the advent of AIDS, on homosexuality and venereal disease in the United Kingdom, where certain clinics in London saw the major part of homosexually contracted syphilis and gonorrhoea. However, as the classic diseases declined interest grew not only in all the other sexually transmitted diseases but also in aspects of HIV infection of concern to clinicians and topical trends in the specialty of major interest. The BCCG, for instance, investigated the provision for sexual health care of adolescents in genitourinary medicine clinics in 1997.³ In the past 5 years there have been five publications from the BCCG, including when to perform the final HIV antibody test following possible exposure⁴; post-exposure prophylaxis (PEP) after non-occupational risk of HIV infection⁵; a survey of genitourinary physicians and vulval clinics,⁶ and an important subject started when I was chairman, syphilis in pregnant women and their children in the United Kingdom, results from the national clinician reporting surveys 1994–7.⁷ Although the incidences of syphilis in pregnancy and congenital syphilis are low, it is partly due to the efforts of this group and the PHLS that antenatal testing for syphilis has been maintained against opposition from some groups.

At the present time, members of the BCCG have ongoing studies on genital herpes, cervical cytology, some aspects of testing for HIV antibodies, the management of cases of child sexual abuse, and a survey on gonorrhoea.

Although the MSSVD now has many special interest groups, the BCCG is a vital part of the mother organisation. It also has a major advantage of being able to make independent studies free from control by governmental bodies. However, the results may influence policy as is seen with antenatal screening for syphilis. This freedom for joint scholarship is essential if specialists are to be advocates for their patients based on sound knowledge. May the BCCG flourish in the new century.

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